Home Health Agency Services

4.231 Home Health Agency Services

4.231.1 Definitions

(a) **"Home health agency"** means a public or private agency or organization, or part of either, that meets the requirements for participation in Medicare, and complies with the Vermont regulations for the designation and operation of home health agencies.

(b) **"Home health agency services"**, for the purposes of this rule, means the services described at 4.231.2(a) that are provided by a home health agency.

4.231.2 Covered Services

(a) Home health agency services are covered when medically necessary. Services that are covered include:

(1) Nursing services,
(2) Home health aide services,
(3) Medical supplies, and durable medical equipment,
(4) Physical therapy, occupational therapy, or speech language pathology services, and
(5) Medical social work services.

4.231.3 Qualified Providers

(a) Home health agency providers must be Medicare certified and enrolled in Vermont Medicaid.

(b) Home health agency services must be ordered by a physician who is enrolled in Vermont Medicaid and working within the scope of his or her practice.

(c) The following non-physician practitioners (NPP) may perform the face-to-face encounter as required in 4.231.4(c) of this rule:

(1) A nurse practitioner, clinical nurse specialist, or certified nurse midwife working in collaboration with the ordering physician, or
(2) A physician assistant under the supervision of the ordering physician.

(d) For beneficiaries admitted to home health agency services immediately after an acute or post-acute stay, the attending acute or post-acute physician may perform the face-to-face encounter.

4.231.4 Conditions for Coverage

(a) General Conditions

(1) Home health agency services are not limited to services furnished to beneficiaries who are homebound.
(2) Coverage of home health agency services are not contingent upon the beneficiary needing nursing

or therapy services.

(3) The beneficiary's condition shall be either an episode of acute illness or injury, or a chronic condition requiring part time or intermittent home health care.

(b) Plan of Care Requirements

(1) Items and services shall be ordered under a written plan of care approved by the ordering physician. The plan of care shall include the following:

(A) The diagnosis, and a description of the patient's functional limitation resulting from illness, injury, or condition,
(B) The type and frequency of medically necessary home health services,
(C) A long-range forecast of likely changes in the patient's condition,
(D) The ordering physician's certification that the services and items specified in the plan of care can be provided through a home health agency.

(2) Initial orders for home health services shall include documentation that the face-to-face visit occurred, as required in 4.231.4(c).

(3) Any changes in a plan of care shall be signed by the physician, or by a registered nurse on the agency staff pursuant to the physician's oral orders.

(4) The plan of care shall be reviewed by the physician, in consultation with home health agency personnel, at least every 60 days.

(c) Face-to-Face Visit Requirements

(1) For the initiation of home health agency services, the ordering physician or NPP must conduct a face-to-face encounter with the beneficiary no more than 90 days prior to, or 30 days after, the start of service.

(2) The face-to-face encounter must be related to the primary reason the beneficiary requires home health agency services.

(3) The face-to-face encounter may be conducted in person or through telemedicine.

(4) The ordering physician must document:

(A) That the face-to-face encounter is related to the primary reason the beneficiary requires home health agency services,
(B) That the face-to-face encounter occurred within the required timeframe,
(C) The practitioner who conducted the encounter, and
(D) The date of the encounter.

(5) The NPP performing the face-to-face encounter must communicate the clinical findings of that face-to-face encounter to the ordering physician. Those clinical findings must be incorporated

into a written or electronic document included in the beneficiary's medical record.

(d) Location Where Service is Provided

(1) Home health agency services may be received in any setting in which normal life activities take place other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities (unless such services are not otherwise required to be provided by the facility), or any setting in which payment could be made under Medicaid for inpatient services that include room and board.

(2) An initial assessment visit to determine the need for home health agency services may be performed by a registered nurse or appropriate therapist in a hospital, nursing home, or community setting.

(e) Requirements Specific to Home Health Aide Services

(1) Services of a home health aide are covered in accordance with a written plan of care ordered by a physician and supervised by a registered nurse, physical therapist, occupational therapist, or speech language pathologist.

(2) The home health aide may provide medical assistance, personal care, assistance in activities of daily living, assistance with a home exercise program, and training the beneficiary in self-help skills.

(3) The home health aide may perform household chores that are incidental to the visit, and specific to the beneficiary.

(4) Supervisory visits by a registered nurse or appropriate therapist must be performed at least every 60 days.

(f) Requirements Specific to Medical Supplies

(1) Medical supplies are covered when they are needed to treat the beneficiary in accordance with the physician-ordered plan of care.

(2) Routine medical supplies used during the usual course of most home visits are included in the home visit charges and not reimbursed separately.

(3) The coverage limitations specific to medical supplies described elsewhere in rule apply to medical supplies provided by a home health agency.

(g) Requirements Specific to Durable Medical Equipment

(1) The rental of certain durable medical equipment (DME) owned by the home health agency and required in the beneficiary's plan of care is covered when conditions of coverage for DME are met.

(2) The DME coverage limitations described elsewhere in rule apply to DME provided by a home health agency.

(h) Requirements Specific to Therapy Services

(1) Physical therapy, occupational therapy, and speech language pathology services are

covered for up to four months per medical condition, based on a physician's order. Provision of these services beyond this initial four-month period requires prior authorization. Therapy services must be:

(A) Directly related to an active treatment regimen designed or approved by the physician, and require a level of complexity such that the judgment, knowledge, and skills of a qualified therapist are required, and
(B) Reasonable and necessary under accepted standards of medical practice for the treatment of the patient's condition.

(2) The physical therapy, occupational therapy, and speech language pathology services described elsewhere in rule apply to therapy services provided by a home health agency.